(D) Clarification

The Secretary shall ensure the public reporting under this paragraph does not contain information that would disclose privileged or confidential information of a group health plan or health insurance issuer offering group or individual health insurance coverage or of a provider or facility.

(8) Administrative fee

(A) In general

Each party to a determination under paragraph (5) to which an entity is selected under paragraph (4) in a year shall pay to the Secretary, at such time and in such manner as specified by the Secretary, a fee for participating in the IDR process with respect to such determination in an amount described in subparagraph (B) for such year.

(B) Amount of fee

The amount described in this subparagraph for a year is an amount established by the Secretary in a manner such that the total amount of fees paid under this paragraph for such year is estimated to be equal to the amount of expenditures estimated to be made by the Secretary for such year in carrying out the IDR process.

(9) Waiver authority

The Secretary may modify any deadline or other timing requirement specified under this subsection (other than the establishment date for the IDR process under paragraph (2)(A) and other than under paragraph (6)) in cases of extenuating circumstances, as specified by the Secretary, or to ensure that all claims that occur during a 90-day period applied through paragraph (5)(D), but with respect to which a notification is not permitted by reason of such paragraph to be submitted under paragraph (1)(B) during such period, are eligible for the IDR process.

(c) Definition

For purposes of this section:

(1) Air ambulance services

The term ''air ambulance service'' means medical transport by helicopter or airplane for patients.

(2) Qualifying payment amount

The term ''qualifying payment amount'' has the meaning given such term in section 1185e(a)(3) of this title.

(3) Nonparticipating provider

The term ''nonparticipating provider'' has the meaning given such term in section 1185e(a)(3) of this title.

(Pub. L. 93–406, title I, §717, as added Pub. L. 116–260, div. BB, title I, §105(a)(2)(A), Dec. 27, 2020, 134 Stat. 2838.)

Editorial Notes

REFERENCES IN TEXT

The Social Security Act, referred to in subsec. (b)(5)(C)(iii), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Titles XVIII, XIX, and XXI of the Act are classified generally to subchapters XVIII (§1395 et seq.), XIX (§1396 et seq.), and XXI (§1397aa et seq.), respectively, of chapter 7 of Title 42, The Public Health and Welfare. For complete classification of this Act to the Code, see section 1305 of Title 42 and Tables.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section applicable with respect to plan years beginning on or after Jan. 1, 2022, see section 105(a)(4) of div. BB of Pub. L. 116–260, set out as a note under section 9817 of Title 26, Internal Revenue Code.

§ 1185g. Continuity of care

(a) Ensuring continuity of care with respect to terminations of certain contractual relationships resulting in changes in provider network status

(1) In general

In the case of an individual with benefits under a group health plan or group health insurance coverage offered by a health insurance issuer and with respect to a health care provider or facility that has a contractual relationship with such plan or such issuer (as applicable) for furnishing items and services under such plan or such coverage, if, while such individual is a continuing care patient (as defined in subsection (b)) with respect to such provider or facility—

(A) such contractual relationship is terminated (as defined in paragraph (b));

(B) benefits provided under such plan or such health insurance coverage with respect to such provider or facility are terminated because of a change in the terms of the participation of the provider or facility in such plan or coverage; or

(C) a contract between such group health plan and a health insurance issuer offering health insurance coverage in connection with such plan is terminated, resulting in a loss of benefits provided under such plan with respect to such provider or facility;

the plan or issuer, respectively, shall meet the requirements of paragraph (2) with respect to such individual.

(2) Requirements

The requirements of this paragraph are that the plan or issuer—

(A) notify each individual enrolled under such plan or coverage who is a continuing care patient with respect to a provider or facility at the time of a termination described in paragraph (1) affecting such provider or facility on a timely basis of such termination and such individual's right to elect continued transitional care from such provider or facility under this section;

(B) provide such individual with an opportunity to notify the plan or issuer of the individual's need for transitional care; and

(C) permit the patient to elect to continue to have benefits provided under such plan or such coverage, under the same terms and conditions as would have applied and with respect to such items and services as would have been covered under such plan or coverage had such termination not occurred, with respect to the course of treatment fur-

nished by such provider or facility relating to such individual's status as a continuing care patient during the period beginning on the date on which the notice under subparagraph (A) is provided and ending on the earlier of—

(i) the 90-day period beginning on such date; or

(ii) the date on which such individual is no longer a continuing care patient with respect to such provider or facility.

(b) Definitions

In this section:

(1) Continuing care patient

The term ''continuing care patient'' means an individual who, with respect to a provider or facility—

(A) is undergoing a course of treatment for a serious and complex condition from the provider or facility;

(B) is undergoing a course of institutional or inpatient care from the provider or facility;

(C) is scheduled to undergo nonelective surgery from the provide or facility, including receipt of postoperative care from such provider or facility with respect to such a surgery;

(D) is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

(E) is or was determined to be terminally ill (as determined under section 1395x(dd)(3)(A) of title 42) and is receiving treatment for such illness from such provider or facility.

(2) Serious and complex condition

The term ''serious and complex condition'' means, with respect to a participant or beneficiary under a group health plan or group health insurance coverage—

(A) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

(B) in the case of a chronic illness or condition, a condition that—

(i) is life-threatening, degenerative, potentially disabling, or congenital; and

(ii) requires specialized medical care over a prolonged period of time.

(3) Terminated

The term ''terminated'' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

(Pub. L. 93–406, title I, §718, as added Pub. L. 116–260, div. BB, title I, §113(c)(1), Dec. 27, 2020, 134 Stat. 2871.)

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section applicable with respect to plan years beginning on or after Jan. 1, 2022, see section 113(e) of div. BB of Pub. L. 116–260, set out as a note under section 9818 of Title 26, Internal Revenue Code.

§ 1185h. Maintenance of price comparison tool

A group health plan or a health insurance issuer offering group health insurance coverage shall offer price comparison guidance by telephone and make available on the Internet website of the plan or issuer a price comparison tool that (to the extent practicable) allows an individual enrolled under such plan or coverage, with respect to such plan year, such geographic region, and participating providers with respect to such plan or coverage, to compare the amount of cost-sharing that the individual would be responsible for paying under such plan or coverage with respect to the furnishing of a specific item or service by any such provider.

(Pub. L. 93–406, title I, §719, as added Pub. L. 116–260, div. BB, title I, §114(c)(1), Dec. 27, 2020, 134 Stat. 2874.)

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section applicable with respect to plan years beginning on or after Jan. 1, 2022, see section 114(d) of div. BB of Pub. L. 116–260, set out as a note under section 9819 of Title 26, Internal Revenue Code.

§ 1185i. Protecting patients and improving the accuracy of provider directory information

(a) Provider directory information requirements

(1) In general

For plan years beginning on or after January 1, 2022, each group health plan and health insurance issuer offering group health insurance coverage shall—

(A) establish the verification process described in paragraph (2);

(B) establish the response protocol described in paragraph (3);

(C) establish the database described in paragraph (4); and

(D) include in any directory (other than the database described in subparagraph (C)) containing provider directory information with respect to such plan or such coverage the information described in paragraph (5).

(2) Verification process

The verification process described in this paragraph is, with respect to a group health plan or a health insurance issuer offering group health insurance coverage, a process—

(A) under which, not less frequently than once every 90 days, such plan or such issuer (as applicable) verifies and updates the provider directory information included on the database described in paragraph (4) of such plan or issuer of each health care provider and health care facility included in such database;

(B) that establishes a procedure for the removal of such a provider or facility with respect to which such plan or issuer has been unable to verify such information during a period specified by the plan or issuer; and

(C) that provides for the update of such database within 2 business days of such plan or issuer receiving from such a provider or facility information pursuant to section 300gg–139 of title 42.